

Health and social care series

Changing models of health and social care

Case studies and supplementary materials



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AUDITOR GENERAL 

Prepared by Audit Scotland
March 2016




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Introduction



This supplement accompanies the main report *Changing models of health and social care*. We have identified a number of new care models introduced across Scotland that are designed to deliver more care to people in community settings in line with the 2020 Vision. At a local level, we have identified different types of care models, including:

- community preventative approaches
- better access to primary care and routine hospital treatments
- enhanced community care models
- intermediate care models
- initiatives designed to reduce delayed discharges.

We have not reviewed all new models in all areas of Scotland. We have selected a number of examples in some areas of Scotland to illustrate the different types of models that exist. We highlight particular aspects of good practice from these case studies in Part 3 of the main report and how these might help NHS boards, councils and integrated authorities overcome some of the barriers to introducing new ways of working.

Most initiatives are at a relatively early stage and have yet to be fully evaluated. This means the potential outcomes for service users and impact on resources are still to be fully established. We were not able to carry out a cost benefit analysis for the care models described in our report owing to a lack of local cost information.

Various principles should be followed for new care models to be implemented, tested, evaluated and rolled out successfully. If local bodies are to expand and roll out new models, they must have thorough information on the costs involved for planning and ensuring the models are sustainable. We summarise principles for implementing new care models in Exhibit 9 in the main report.

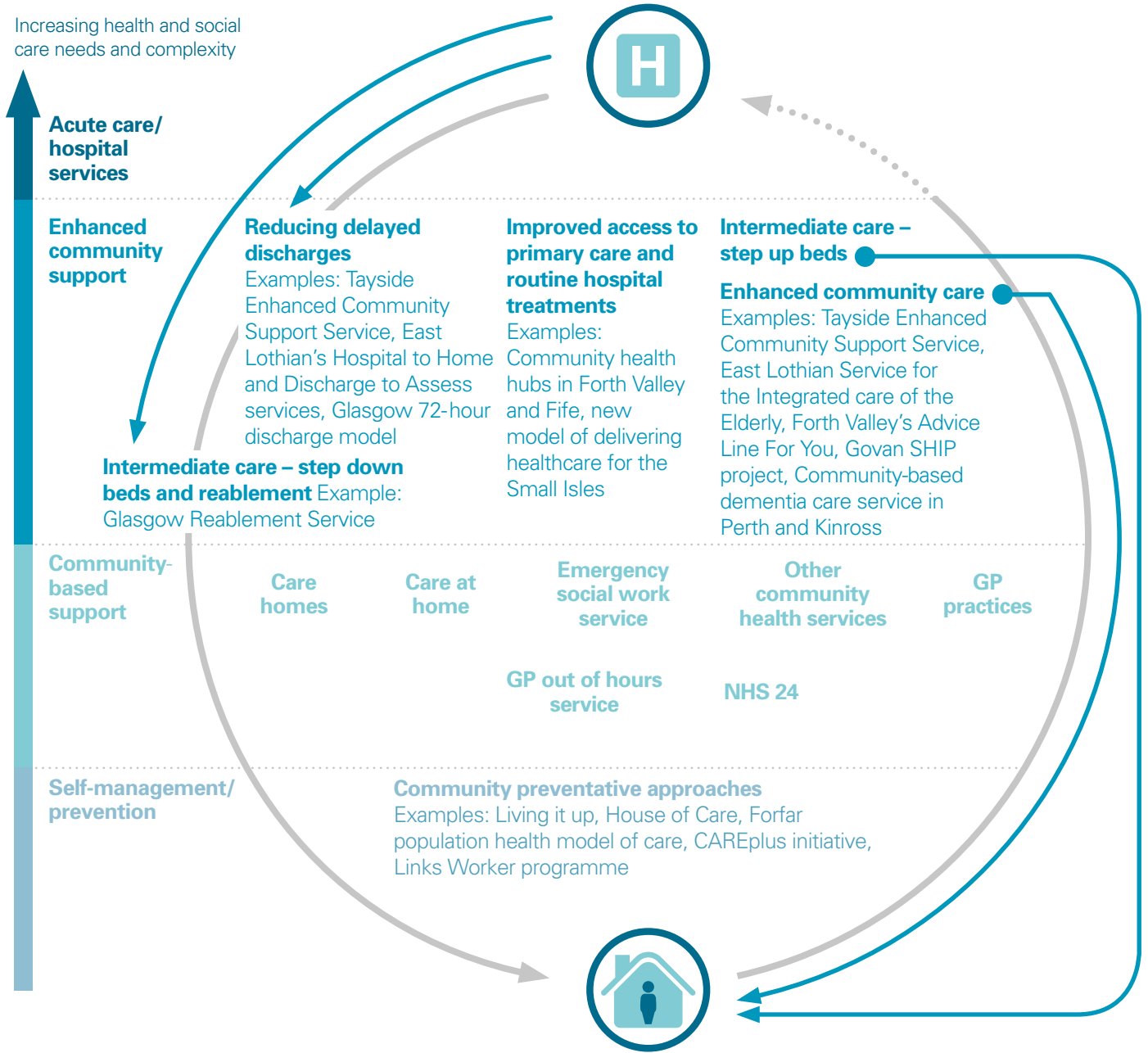
System diagram of new care models



Most new care models are designed to relieve pressures on the acute sector but they can have an impact on different parts of the health and social care system. A high-level system diagram showing where the models of care (described in Exhibit 6 in the main report) sit within the overall health and social care system is set out on [\(page 6\)](#). Many of these care models are described in more detail in the following case studies.

This diagram shows the different types of models in the context of people's increasing health and social care needs and the complexity of care they require. The different types of models aim to provide the most appropriate care in the most appropriate setting, and wherever possible in the person's home or a homely setting in the community. Where hospital care is the most appropriate option, there are models that support quicker discharge of people, with ongoing care needs, back into the community.

System diagram of new care models



Case studies



Case study 1



Two GP surgeries in Forfar are joining together to deliver a population health model of care based on the Alaskan Nuka model of care

A GP practice in Forfar is developing a new model of care to improve access, health and wellbeing and sustain services in the longer term.

Forfar model

Patients and staff in Forfar have been involved in designing a new model of primary care, due to be launched in 2016, that aims to ensure that:

- patients are seen in the right place at the right time by the right person
- patients are encouraged to take control of and manage, their own care with support from staff, and that patient experience and outcomes are positive
- staff are positive about making the model work, and their skills are used effectively, and that the practice is profitable and able to continue over the longer term.

The merged practice will split into small integrated teams each working from the same site. The teams will include GPs, nurses, healthcare assistants, administrative staff and community nurses, each looking after a population of around 2,820 patients. Each patient is looked after by a small team to enable continuous care by the same professionals and develop positive relationships. The team will aim to provide as much support as they can every time the patient needs to attend the practice to reduce the need for return visits. Patients will speak to a member of the team before they attend the practice to work out which members of staff they should see when they come in. The practice will carry out all tests and investigations at the same time if possible. There are plans for each team to also provide a psychology and a social prescribing service (linking people up to activities in the community they might benefit from).


Nuka model

The Nuka model of care from Alaska has influenced the model the Forfar population is developing. Multidisciplinary teams provide integrated health and care services in primary care centres and the community. These are coordinated with a range of other services and combined with a broader approach to improving family and community wellbeing. This includes education, training and engaging with the community across the population about issues such as abuse, neglect and domestic violence. All of Nuka's services aim to build on the culture of the Alaska Native community.

Native Alaskans create, manage and own the whole healthcare system. They do this by:

- being actively involved in the management and governance structure
- participating in advisory groups in their local areas
- taking part in surveys, focus groups and telephone hotlines used by managers to ensure that people can give feedback that is acted on.

Since it was established, the Nuka model of care has significantly improved access to primary care services. Customer satisfaction has increased and there have been large reductions in emergency care and hospital admissions.

Source: [Transforming Primary Care Service Delivery in Forfar, Creating a healthier Scotland website, 2015](#) ; *Nuka system of care*, Alaska, King's Fund, 2015

Case study 2



Tayside's older people locality model and enhanced community support service

Tayside has combined its older people locality model that aligns consultant geriatricians to GP practices, with an enhanced community support service.

The Tayside approach aims to:

- prevent older people at risk of an unplanned hospital admission being admitted by identifying them and giving them an enhanced level of support at home before they reach crisis point
- facilitate patients' discharge from Ninewells (the acute hospital) to home or to a more homely setting, such as a community hospital.

The enhanced community support service is delivered by a multidisciplinary team (MDT) at GP practice level. The patient's assessment is led by the GP while the enhanced care package tends to be coordinated by either an advanced nurse practitioner specialising in medicine for the elderly or a senior district nurse with time protected for the assessment of frail people and care coordination. The MDT, which also involves nurses, community pharmacists, allied health professionals, community mental health staff and social workers, meet weekly to discuss patients currently receiving the enhanced service and to identify others who could benefit from the service. The teams also have links with the voluntary sector.

What makes this model different from others in Scotland is the integration of care between the primary and acute sectors in local areas through the alignment of consultant geriatricians with GP practices. As well as attending the weekly practice-based MDT meetings, the consultant geriatrician will be involved in the care of any patients from that practice admitted to hospital. They will be well placed to advise the MDT on what will be required to be in place for individual patients to be discharged from hospital, providing a continuity of care.

Three council areas within NHS Tayside, Dundee City, Angus, and Perth and Kinross, have developed this approach at different rates. As they have done this they have built on existing services and improvement work and responded to the specific needs of the area. Across Tayside, as at September 2015, the model covered 27 per cent of people aged over 75. The three areas within Tayside are continuing to roll out this approach.

Source: Audit Scotland

Case study 3



The impact on patients of new approaches to patient care in Govan

Patient stories describe how the Govan SHIP (Social and Health Integrated Partnership) project made a difference to the number of attendances at A&E for one individual and how the care of an elderly person with dementia was improved.

Three new, linked approaches to delivering health and social care have recently been introduced in Govan, one of the most deprived areas in Scotland:

- The Govan SHIP project aims to reduce demand on acute and residential care and improve chronic disease management. Four GP practices in Govan Health Centre are involved in the project, which adopts a multidisciplinary approach. Each multidisciplinary team (MDT) is made up of professionals from across hospitals and the community, including social care, and manages patients in crisis. The patients selected for the project are children and adults who are known to be vulnerable, for example people with mental health problems and/or addiction issues, people who use services frequently and older people and adults with complex needs.
- Patients with complex and/or multiple conditions may be eligible to be part of the CAREplus initiative. Inclusion allows patients to be given longer consultations with a GP or nurse. This enables them to discuss their problems in more detail and make a list of priorities.
- The Scottish Government-funded Links Worker Programme has placed community links practitioners in two GP practices in Govan. They are not medically qualified, but link practices and patients with community-based services and resources such as lunch clubs and self-help groups based on individual patient's needs.

The Govan SHIP project has developed patient stories to illustrate the difference the new approaches in Govan have made since they were introduced in April 2015.

Patient story 1

This story concerns a 22-year-old with known personality disorder and anxiety illness. In seven years, this person had presented to A&E 590 times. Multiple agencies were involved in the person's care, including psychiatry, general practice, emergency care, third sector support agencies and a prison liaison officer.

By including this individual in the Govan SHIP project, the GP's time could be freed up by one of the two locum GPs funded through the project, to allow them to attend regular meetings about the care of the person. These were also attended by psychiatry, a prison officer, social work, A&E and GP out-of-hours colleagues. A plan for a regular, prolonged, 30-minute appointment with the GP was instigated with weekly follow-up by community psychiatric nursing and a clear plan for out of hours was written and documented.

Prior to involvement in the project, the person had attended A&E 30 times between November 2014 and January 2015. Since the person began regularly attending GP appointments in January 2015, there have been only six presentations between May 2015 and July 2015.

Patient story 2

This story concerns a 66-year-old with dementia whose social circumstances are extremely poor. The person's carer is their daughter who has serious addiction issues. There were significant concerns for this person's safety at home although they wished to remain there and had the capacity to make that decision.

Enrolling this patient in the Govan SHIP project allowed a round-table discussion with multiple agencies. This included joint visiting with social work and addiction teams who were involved with the carer and also by psychiatry. GP attendance at multidisciplinary meetings allowed for the sharing of additional information, which could then be passed on to the carer. This resulted in enhanced engagement with the carer, care staff and social work. A plan was set in place to allow Cordia (home care provider) to gain access for personal care and support and for Key Housing (housing association) to assist in improving the standard of cleanliness within the home.

Without involving this person in the project, the GP would not have been able to attend MDT meetings. Engagement with the carer and the multiple agencies involved in the person's care would also have been much more difficult.

Source: Audit Scotland; [The Govan SHIP \(Social and Health Integrated Partnership\) Project, Creating a healthier Scotland website, 2015](#) 

Case study 4



The Buurtzorg model of care

The Buurtzorg approach is an internationally renowned model of care from the Netherlands.

Founded in the Netherlands in 2006/07, Buurtzorg is a unique district nursing system which is internationally renowned for being entirely nurse-led and cost effective. Before Buurtzorg, home care services in the Netherlands were fragmented with patients being cared for by multiple practitioners and providers.

Ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce. They were unable to properly care for patients with complex needs and this led to a decline in patient health and satisfaction.

Buurtzorg's answer to this problem was to give its district nurses far greater control over patient care. Nurses lead the assessment, planning and coordination of patient care. The model consists of small self-managing teams with a maximum of 12 professionals including nurses and allied health professionals such as occupational therapists. These teams coordinate care for a specific catchment area.

The Buurtzorg service:

- provides a holistic assessment of an individual's needs, including their medical, personal and social care needs, that feeds into a care plan
- identifies networks of informal care and assesses ways to involve these carers in the individual's treatment plan
- identifies any other formal carers and helps to coordinate care between providers
- delivers a range of care from basic nursing to palliative care
- supports clients in their home
- promotes self-care and independence.

Source: *A new perspective on elder care in the Netherlands*, The Journal (AARP International), 2011

Case study 5



Forth Valley's Advice Line For You (ALFY)

Forth Valley has combined a nurse-led telephone advice service with a focus on self-management of care.

Forth Valley's ALFY model is a nurse-led telephone advice service designed to support older people to remain well at home. It is aimed at people aged 65 and over and their carers and is available 24 hours a day, seven days a week. The initiative was successfully piloted in Bo'ness and has recently been rolled out across Forth Valley.

Experienced nurses provide advice and support at points of uncertainty or crisis. Support ranges from:

- providing general health advice and reassurance
- arranging a nurse assessment and organising a home visit day or night
- organising for certain equipment to be provided to support people at home
- arranging an appointment to attend the Rapid Access Frailty Clinic at the acute hospital
- providing access to general or specialist medical advice or review as required
- arranging a referral to the community rehabilitation service
- prioritising access to social care services determined by need
- giving people information about local voluntary organisations.

As part of the initiative, older people are also encouraged to develop a personal care plan known as Your Plan and share this with their family, and those people closest to them, as well as health and care professionals. Your Plan allows people to document in one place all the important things that matter to them about their health and care needs. By sharing this information, everyone will know what to do if a problem arises and what support they could give to help people maintain a good life.

Source: Audit Scotland; <http://nhsforthvalley.com/alfy> 

Case study 6



The Scottish Ambulance Service's longer-term strategic approach

The SAS's strategy aims to treat more patients in the community.

The Scottish Ambulance Service's five-year strategy *Towards 2020: Taking Care to the Patient* aims to increase the proportion of patients treated at the scene. The service developed the strategy in consultation with stakeholders and the general public. It has been built around the levels of emergency categories and the top ten conditions of patients they treat. The different types of patients' conditions require quite different responses, for example around 40 per cent of patients require immediate emergency care that will require them to be treated in a hospital. Around 60 per cent have a minor ailment or an exacerbation of a long-term condition that could potentially be treated in the community or require more diagnostic assessment to ensure they get to the right place for treatment first time.

This approach requires closer working with primary care to ensure patients are referred to the most appropriate service. This ensures they are treated in the community, if appropriate, with adequate support. The SAS is also investing in:

- technology to improve diagnostics and treatment provided on the scene
- training and skills development of the workforce in treating common long-term conditions and more preventative approaches to keep patients at home or in a homely setting.

Examples of the approaches the SAS is implementing as part of their strategy include the following:

- In NHS Borders and Lothian, ambulance staff are developing extended skills to enable them to operate as practitioners to see, treat and discharge, or refer patients. This allows patients to remain at home or in the community.
- In Grangemouth, paramedics are working within general practice during normal hours from Mondays to Fridays.
- In NHS Lanarkshire, the SAS is helping to develop an Age Specific Service Emergency Team (ASSET) hospital at home service for frail and elderly patients who are over 75 in North Lanarkshire.
- A system for dealing with falls across all 32 partnership areas in Scotland. Evidence shows that in around 40-50 per cent of calls to the SAS, the person is uninjured. However, previously the SAS had little or no access to community services, as an alternative to taking the patient to hospital. More recently, the SAS has worked with partnerships to get rapid access to falls teams to reduce the number of people who are taken to hospital due to a fall.

The strategy is backed up by a workforce development plan, a digital technology plan, and a financial plan. The first year of the plan has been funded by non-recurring funding. But the SAS will require extra funding each year to implement the subsequent four years of the plan up to 2020. The Scottish Government has approved the strategic and financial plans outlining an additional recurring investment of around £21.4 million over five years, with equal levels of additional expenditure required. In its draft budget for 2016-17, the Scottish Government plans to increase revenue funding to the SAS by 1.7 per cent and to allocate a recurring amount of £5 million to support the five-year strategy.

Source: Audit Scotland; *Towards 2020: Taking Care to the Patient*, Scottish Ambulance Service, 2015

Case study 7



Scottish Centre for Telehealth and Telecare (SCTT) Technology Enabled Care (TEC) Programme

The TEC programme is encouraging more use of tried and tested technology to help improve health and wellbeing outcomes.

Telehealth and telecare aim to improve outcomes for individuals in their homes or in community settings by using technology as an integral part of their care and support. Examples of telehealth and telecare approaches include:

- door contact alarms for people with dementia
- using video-conferencing to diagnose patients in remote areas
- using home health monitoring devices, such as oxygen gauges, for patients suffering from lung disease
- making online information available so people with long-term conditions can take control of their own care.

These resources can help people maximise their independence and provide support to carers, as well as preventing them from being admitted to hospital and, if they are, making it easier for them to get an earlier discharge.

The SCTT Technology Enabled Care (TEC) Programme is a £30 million initiative to encourage more use of tried and tested technology to help improve health and wellbeing outcomes from 2015 to 2018. The programme was developed after evidence from the Joint Improvement Team's review of the Telehealth and Telecare Delivery Plan. It found that many small-scale projects in this area had no clear plans on how to make them available to more people.

The TEC Programme focuses on scaling up five key areas that have proven to work to make them sustainable in the longer term:

- home health monitoring
- NHS video-conferencing
- telecare packages
- online platforms that give people direct access to information, advice and assistance
- switching telecare from outdated, expensive, telephone-based technology to more efficient and integrated digital technology.

Source: Audit Scotland; Scottish Centre for Telehealth and Telecare; Joint Improvement Team

Case study 8



Examples of overcoming barriers to directing funding to new care models

Some local areas are finding ways to direct more funding to community-based care models.

Moving money away from institutional-based care

There are some examples of disinvestment in small community hospitals, rather than large acute hospitals, to increase investment in community-based care models. NHS Tayside has closed beds in a number of community hospitals to fund services in more homely settings. In Angus, the closure of a community hospital helped to fund the enhanced community support service ([Case study 2](#)). In Perth and Kinross, the closure of a number of community hospital dementia beds released resources to help develop community older people mental health teams. In the Strathmore area, the year before the hospital dementia unit closed, 40 patients were admitted for acute dementia assessment or intervention. The community-based team now provides care for over 800 people living with dementia in their homes. In Pitlochry, the dementia unit was closed. This allowed the board to transfer staff into the North West community-based mental health team. In the previous year, 19 patients were admitted into the hospital unit. The team is now visiting around 300 patients in their homes. These services were developed without any additional funding, apart from a small amount of money to support project management and training and development of staff in the Strathmore service.

Community interventions to release more funding

Glasgow City Council, in partnership with NHS Greater Glasgow and Clyde, has a reablement programme to support people to remain at home safely and independently for as long as possible. With increasing demand for home care services, it has freed up resources, including money and staff, to allow more home care services to be provided. People referred for home care are assessed to find out if they are suitable for the reablement programme. Over the last three years, on average around 40 per cent of people who have completed the programme required no further home care. For people who require ongoing support there has been around a 20 per cent reduction in home care packages. The reablement programme released cash savings in the home care budget of £2.75 million in 2013/14 and £1.75 million in 2014/15. For 2015/16, Social Work has set a target to make efficiency savings of ten per cent across all care at home services, including reablement, provided by external provider Cordia.

Source: Audit Scotland

Case study 9



Examples of redirecting resources to priority areas

Some local areas are using tools to manage scarce resources and competing demands.

Some areas are adopting a programme budget and marginal analysis (PBMA) approach. This considers:

- how current available resources are used
- if more resources should be directed to certain services or groups of people
- where care could be provided more efficiently and more resources redirected to priority areas
- areas of care where fewer resources should be allocated as they could be used more effectively in priority areas.

Perth and Kinross Partnership

- Perth and Kinross Council and NHS Tayside have carried out extensive analysis to gain a better understanding of the population and how people are using local health and social care services. They have found that there is considerable variation across the whole partnership area and also within local areas.
- They are currently considering how they can use the PBMA approach to reduce the level of variation and better use their resources. They are currently developing 'fair local area consumption targets'. These are based on current consumption patterns and include an efficiency component to stretch and encourage better use of resources.
- Each local area would receive a notional budget based on a consumption rate, multiplied by the weighted population. They would be able to compare this against current consumption to identify the potential they can gain from improving services and how their population accesses them. They would also be able to benchmark against other areas.
- It is hoped that benchmarking and discussions across local areas will drive changes in clinical decisions and lead to less variation and consumption levels closer to the 'fair consumption target'.
- The benefits of this approach are not just expected to be monetary. The aim will be to encourage more integrated working, more engagement and understanding of the range of community resources and assets, and to achieve better outcomes for the local population.
- The PBMA programme aims to give an incentive and identify opportunities and priorities to shift the balance of care away from high-cost hospital and care homes towards more community-based services in local areas.

South and Mid-Highland care at home services

- In Highland the PBMA approach was used to look at reform of care at home services in South and Mid Highland. This had previously been seen as too big an issue to tackle all at once. The care at home services provided by the council had received poor quality ratings and there were difficulties in recruiting staff. Along with some closures and suspension of admissions to care homes, based on quality issues, this was having a negative impact on delayed discharges from hospital owing to lack of care provision.
- A development group was set up to examine how care at home services could be expanded to meet increasing need, and the quality of care improved. The main aim was to provide more home care hours, more efficiently by recruiting and retaining good staff.
- At the time the new model was developed, NHS Highland was purchasing care at home services from the independent sector at £15.97 an hour, while the in-house service cost was about £29 an hour. The independent sector hours were also delivered at a higher quality grading and with greater flexibility.
- The approach the group took was to shift to more independent care at home services, suspend in-house recruitment of care at home staff, and to increase the hourly purchase rate by £0.75 to move closer towards a living wage. (The UK Home Care Association calculated the hourly rate councils should pay to providers in order to comply with the UK living wage was £18.59 – applicable at November 2014.)
- This resulted in a reduction of 12 whole-time equivalent in-house staff and £288,000 was reallocated from in-house services to the independent sector and self-directed support (around 4.5 per cent of the overall budget). There has been a decrease in the number of people delayed from discharge from hospital. It is less than the group predicted, but it may be too early to see the full impact of the change which was implemented in late 2014.
- The group decided to implement the full living wage for independent sector staff from May 2015, at an additional cost of £767,000. This is to be financed by an accelerated reduction in the in-house service and non-recurrent funding of £500,000 to fund the double-running costs in 2015/16.

Source: *Developing priority setting processes in Health and Social Care Partnerships: learning from the pilot sites*, Scottish Public Health Network, November 2015

Case study 10



Examples of shifting resources to community-based settings from other countries

In Canterbury, New Zealand, a long-term transformational programme and integrated system has increased investment in community-based care and shifted the balance of care.

From 2007, the District Health Board for Canterbury has been working towards an integrated health and social care system. It was initiated by the chief executive at the time, who recognised that the current way of operating was unsustainable. There was increasing pressure on hospital beds, long waiting times for patients, inefficient use of resources and the board was running a deficit against its budget.

Staff were fully involved in developing a long-term vision for what the health and social care system should look like in 2020, and how it should be changed. They were given explicit permission by the chief executive to change the system. A set of strategic goals and principles were agreed about how the system should develop and what it should look like. These placed the patient very much at the centre.

A focus on transformational change across the whole system led to hospital clinicians and GPs working together to achieve the same vision: shifting much more care into the community and reducing inefficiencies in the system. Although the new community models required considerable additional investment, the Board also reviewed spending in a number of areas. It reduced spending in areas with low impact and prioritised spending to those in greater need to reduce the reliance on residential care and keep people in their own homes for longer. This had the effect of reduced demand and costs for hospital and other institutional care, allowing for more investment in the community.

Key success factors of the approach in Canterbury include:

- strong leadership
- agreeing a clear vision that staff are signed up to and know what they are working towards
- a collaborative and whole system approach – 'one system, one budget'
- investment in large-scale, transformational change
- sustained support and investment in providing staff with the skills needed to innovate
- making the system more efficient and making best use of the existing budget.

Source: *The quest for integrated health and social care: A case study in Canterbury, New Zealand*, The King's Fund, September 2013

Case study 11



Examples of overcoming workforce challenges to providing new care models

Some areas are developing models with other professionals taking over part of the GP role or supplementing it.

Govan Social and Health Integrated Partnership (SHIP) project

The budget for the SHIP project ([Case study 3](#)) includes funding for two locum GPs. This provides protected time for GPs involved in the project. It also allows them to provide extended consultations to patients with complex needs and take part in other clinical and project development activities.

Community Links Practitioners, whom we refer to in [Case study 3](#), also help to relieve pressure on general practice and the limited time GPs have to spend with patients. They are able to spend time with patients to understand the wider non-medical issues that may be affecting their health and help them get access to suitable resources within their community that can benefit their health. This might include social and lunch clubs, self-help groups, befriending organisations, and employment or voluntary-work agencies.

Increased use of advanced nurse practitioners in NHS Grampian's out-of-hours service

Advanced nurse practitioners (ANPs) are highly qualified nurses, who have the clinical expertise, knowledge and experience needed to work at an advanced level of nursing practice. They are able to act as a senior clinical decision-maker, with the authority and autonomy to make complex decisions about a patient's care.

GMED is NHS Grampian's urgent medical service when GP practices are closed. The GMED team is made up of a range of health professionals and support staff including GPs, advanced nurse practitioners, drivers and call handlers. As fewer GPs choose to do out-of-hours shifts and with evidence that GMED ANPs can manage approximately 95 per cent of patients, GMED has employed an increasing number of ANPs.

The 2015 national review of primary care out-of-hours services recommended the introduction of a similar GP-led model delivered by a multidisciplinary team. The principle behind the model is that patients will be seen by the most appropriate professional to meet their individual needs. That might not be a GP but could be a nurse, or a physiotherapist or social worker.

East Lothian hospital at home and integrated care model

This model provides local GPs direct access to emergency care at home for their patients with a single point of contact for people who are at risk of admission to hospital. It also allows patients to be discharged earlier from hospital and supported at home. The system works by local GPs taking over responsibility for the local population's health and social care needs, including triaging, treating and directly admitting patients to local hospitals if required. Advanced nurse practitioners are picking up some of the GPs' role, including home visits and prescribing and a key improvement has been supporting and addressing significant GP workload in care homes. In addition to nurses, the extensive multidisciplinary team includes a consultant physician, physiotherapist, occupational therapist, pharmacist, community psychiatric nurse, carer link worker, and dedicated emergency care support and input by social work. The team has a 'huddle' (a short meeting) every day to discuss the care patients need and any follow-up required once patients have been discharged from the service. To do this, the team liaises closely with GPs and district nurses as well as acute hospitals. The service is soon to extend to a 24-hour, seven day service and is working with the local primary care out-of-hours service to develop referral routes.

Source: Audit Scotland; *Nurse Innovators: Clinical Decision-making in Action*, RCN Scotland, 2015; *GMED Out of Hours Service Information for Patients, Carers, Public and Interested Parties*, NHS Grampian, January 2011; *Main Report of the National Review of Primary Care Out of Hours Services*, Scottish Government, 2015

Case study 12



Examples of local areas making good use of data analysis

Some areas are making good use of data analysis to understand their local population and redesign services.

High resource individuals (HRIs) Across Scotland a small number of people with complex needs use a large amount of the overall resources in the health and social care system. This analysis has revealed that costs for each person vary vastly. The data is available at an individual level which allows local areas to examine the use of services by HRIs and how costs are incurred.

For example in Perth and Kinross, analysis of one general practice population showed that five per cent of the population (fewer than 150 people) used 54 per cent of the resources (£3.8 million). This pattern of a small number of people (2-5 per cent of each partnership) consuming about 50 per cent of all expenditure is replicated across Scotland. Local analysis has shown that people in the least deprived areas and in urban areas are higher users of services than those in more deprived areas and in rural areas. It has also shown that people who are high users of NHS services tend to be low users of social care services and vice versa.

End of life care and costs This is linked to HRI analysis. In the last 6-12 months before death, people tend to use significantly more health and social care services, particularly acute hospital services, and this results in higher costs. ISD and some local areas have been analysing the pattern of care for individuals to understand what this looks like and if care can be provided differently.

For example, East Lothian has one of the highest end-of-life care costs in Scotland. It also has one of the highest rates of people dying in hospital. Care home costs are also a significant part of the costs. The partnership is examining local data to better understand this pattern and find out if people are being admitted to hospital from care homes, from care homes to hospitals, or both. It is trying to determine if there is more it can do to prevent admission to hospital by providing more care in care homes or if there are different ways to deliver care other than in a care home.

Understanding the local population and projected use of services NHS boards and councils need to have good intelligence on the profile of the local population to understand current and future needs, and to plan future services.

For example, West Dunbartonshire has carried out analysis of long-term conditions within the local population, including service use and the associated costs, along with projections of the population and future demand for services. It is using this information to inform its strategic planning. It is also using this local intelligence for anticipatory care planning and identifying older people at risk of admission to hospital. The information is available to the whole health and social care team and has allowed resources to be directed towards additional support and community-based alternatives to hospital care.

Links to useful information



We have drawn together links to various reports, toolkits and websites that NHS boards, councils and partnerships may find useful when developing new models of care.

| Link to report, toolkit or other summary information | Description of information |
|---|--|
| Information Services Division (ISD) Population needs assessment for health and social care partnerships | This document provides guidance on data sources available to support a local population needs assessment. |
| NHS Scotland Quality Improvement Hub Improvement journey | This website describes seven stages of implementing improvements, with questions at each stage and links to tools. |
| Scottish Ambulance Service (SAS)/ Joint Improvement Team (JIT) Making the Right Call for a Fall | This document provides practical guidance and case studies to help health and social care professionals, planners and managers. Although aimed at falls prevention, it has a useful checklist at the end about how to make organisational change work and questions to consider for implementing service redesign. |
| Scottish Government 3-step Improvement Framework for Public Services | A framework developed to help achieve significant lasting improvement across public services. It is designed to prompt self-assessment and debate, and to encourage those working in public services to create the conditions for, and implement, the improvements that will make a difference. |
| Scottish Public Health Network Developing priority setting processes in Health and Social Care Partnerships: learning from the pilot sites | This report describes the use of Programme Budgeting and Marginal Analysis (PBMA), an analytical approach to assessing the costs and benefits of alternative courses of action. It can enable health and social care partnerships to identify the potential effect of shifting patterns of investment, and disinvestment, within and between programmes of activity – in terms of outcomes for patients and service users, and effective use of resources. |
| NHS England New care models 'Vanguard sites' Planning support tools | These websites provide details of the new models of care being tested in NHS England and planning tools to support commissioners. |

| Link to report, toolkit or other summary information | Description of information |
|--|---|
| <p>Health Foundation</p> <p>Information on spreading improvement</p> | <p>This blog by the Health Foundation talks about how to replicate and spread good practice and includes links to a number of resources on its website for scaling up and rolling out new ways of working.</p> |
| <p>The King's Fund</p> <p>Transforming our health care system: Ten priorities for commissioners</p> <p>Place-based systems of care</p> <p>The quest for integrated health and social care: A case study in Canterbury, New Zealand</p> | <ul style="list-style-type: none"> • The King's Fund is an independent charity working to improve health and care in England. It publishes a large number of reports and briefing papers that are equally as relevant to health and social care services in Scotland. We have highlighted a few reports with useful checklists or tools. • Ten design principles to guide systems of care (page 12) • Emerging examples of place-based systems of care in the NHS (page 30) • 'Pictogram' of the new health and social care system in Canterbury (page 9) |
| <p>Nuffield Trust</p> <p>Evaluating integrated and community-based care: How do we know what works?</p> <p>Developing evaluation methods to help the NHS provide care more effectively</p> | <p>The Nuffield Trust has undertaken evaluations of over 30 community-based interventions designed to reduce emergency hospital admissions. This report presents the key learning from these studies.</p> <p>The Nuffield Trust is developing a page on its website that will pull together developments from its research project to develop evaluation methods further, including published papers and details of events.</p> |
| <p>ALLIANCE Scotland</p> <p>Scotland's House of Care</p> <p>Year of Care House</p> | <p>The Year of Care Partnerships developed a collaborative care planning approach to support people with long-term conditions. It is being tested in a number of areas in Scotland.</p> |



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ISBN 978 1 909705 84 5 AGS/2016/02

This publication is printed on 100% recycled, uncoated paper

